File number: 26911132

Chinese Medical Report

该患者从大同（北京西北的城市）转至我院。患者在大同时，因 Post dramatic stress，背部疼痛，双腿麻痹就诊。这个结果是由越南遭受枪击导致的。检查查出患者 2 级心衰，建议转入北京就医。

患者转入解放军 306 医院时，心脏衰竭已经恶化至 4 级。

患者病史：

1977 年，病人遭受他第一次心梗。在 1990 年又发生 3 次。1992 年,被送往俄亥俄州托莱多圣文森特医院接受打开心脏手术 (10 5 1992)。

手术: Wa Lima-Lad Svg-Rca，ID 号：475736－0，医生: Sugeon A.Zacharias

患者多年来病情持续恶化，2006 年又发生一次心梗后，手术植入心脏起搏器。

心脏科医生们认为：患者的心脏状况与患者在越南与柬埔寨美军服役期间，遭受的橙色落叶剂直接相关。

结论：病人的缺血性心脏病，严重受损的心肌梗塞等系列心脏病症是接触橙色剂造成。

患者的心脏状况不会有好转或改善。

他的状况被视为 100%残疾，不具备工作能力。

File number: 26911132

English Translation

The Patient was referred from Datong, China in eastern China to Beijing, to seek treatment for 2nd stage heart failure. The patient was being treated in Datong for severe Post dramatic stress and pain and numbness in his legs and back. The results of a gun shot wound received in Viet Nam during.

During the one of his visits in a routine check up it was discovered the patient was in the early stages of second stage heart failure.
The patient was admitted to Beijing Hospital # 306 People's Liberation Army Military Hospital in Beijing and his condition had already deteriorated to 4th stage hear failure.

Patients History.
The patient suffered his first myocardial infraction in 1977, 3 more in 1990. And 1999, where he was admitted to St Vincent's Hospital in Toledo Ohio where he under went open heart surgery (10 5 1999)

Operation preformed Wa Lima-Lad Svg-Rca file number 475736-0 as related by his surgical ID card, Surgeon A. Zacharias.

The patients continuing deterioration over the years required him to be surgically fitted with a Defibrillator and Pace maker in 2006 after suffering yet another heart attack.

In the opinion of this Physician and the Physicians of the Coronary care unit
This patient condition is directly related to prolong exposure to Agent Orange while serving in the U.S.Army in Viet Nam and Cambodia.

Conclusion Patient is suffering from Ischemic Heart Disease .
This patient's heart is severely damaged due the series of myocardial infractions and exposure to Agent Orange.

It would be impossible for this patient to ever recover from this condition.

He is consider 100% disabled and would never be able to engage in employment.

Face Sheet/Discharge Summary Report

Date: 09/17/2007 **Clinician:**

Status: Preliminary **Encounter:** #104597463- The Toledo Hospital **POC:**

PLEASE NOTE: Above date represents the date this report was posted to the CDR, see report content below for the actual exam/observation date.

The Toledo Hospital
Discharge Summary

Patient Name	Dictated By	Admission Date	Unit	Room History #
HALL, Bryce M	Joel L Cohen, D.O.	09/02/2007	85454	0711-01

D.O.B. 11/20/1949
ACCOUNT #: 104597463
DISCHARGE DATE: 09/05/2007
DIAGNOSES:
1. Acute myocardial infarction.
2. Severe left ventricular dysfunction.
3. Coronary artery disease.

HISTORY OF PRESENT ILLNESS: The patient is a 57-year-old male status post CABG who presented with chest pain, was thought to have EKG changes and continued chest pain. He underwent an emergent cardiac catheterization, which showed that his left main was normal. LAD was 99% proximal stenosis. A high _____ has 70% stenosis and circumflex artery was totally occluded proximally. The RCA was totally occluded with large collaterals to the circumflex artery. There was a LIMA to the LAD, which was widely patent, an SVG to an RCA, which had a 30-40% proximal stenosis. LV gram showed inferior wall and apex akinetic with moderate-to-severe decrease in LV systolic function. An attempt was made to open up the circumflex artery, which was unsuccessful. The patient was placed on Integrilin, heparin, and Plavix. His troponins increased to 30.9. He was chest pain free. His troponins finally started to decrease. An echocardiogram was done, which showed the LV was moderately dilated. The LV systolic function was moderate to severely reduced. Right ventricle was normal in size and function. Left atrium was mildly dilated. There was moderate mitral regurgitation. There was trace TR. The patient continued to do well. He was discharged to home in good condition on following medications, aspirin 325 mg daily, Lopressor 25 mg b.i.d., lisinopril 2.5 mg daily, and Crestor 5 mg daily. He will follow up with Dr. Cohen in 4 weeks. A discussion was held with the patient concerning the need and appropriateness of an AICD. He had agreed to this and he will also follow up with Dr. Sarikonda. He will be discharged to home in good condition on the cardiac diet.

Joel L Cohen, D.O. Date

JLC/8423 D: 09/16/2007 09:46 T: 09/16/2007 J#: 273694

Emergency Room Report

Date: 09/05/2007 **Clinician:**

Status: Preliminary **Encounter:** #104597463- The Toledo Hospital **POC:**

PLEASE NOTE: Above date represents the date this report was posted to the CDR, see report content below for the actual exam/observation date.

The Toledo
Hospital
Emergency Center Report

Patient Name	Dictated By	Admission Date	Unit	Room History #
HALL, Bryce M	Russell L. Johnson, D.O.	09/02/2007	85454	0711-01

ACCOUNT #: 104597463

Fifty seven year-old gentleman with chief complaint of chest pain, left arm pain, it started about 4:30 this morning. Chest pain with left arm pain, nausea, associated shortness of breath associated and he was sweating quite profusely. Symptoms by the time he arrived to the Emergency Dept. 3-4/10. Nothing seemed to make it better, nothing seemed to make it worse. He did take an aspirin prior to arrival.

REVIEW OF SYSTEMS: All reviewed and negative otherwise except as noted in chief complaint.

PAST MEDICAL HISTORY: Positive for coronary artery disease. He had a coronary artery bypass graft back about 17 years ago.

MEDICATIONS: None.

ALLERGIES: None.

PHYSICAL EXAMINATION

VITAL SIGNS: Blood pressure 116/76, pulse 65, respirations 16. He is awake, alert, oriented times three appears uncomfortable, but in no acute distress.

Skin is slightly diaphoretic.

Head is normocephalic, atraumatic. Pupils are equal. Extraocular eye muscles are intact

Neck is supple.

Lungs are clear.

Heart tones are regular.

Abdomen is soft, nontender.

Extremities show no clubbing, cyanosis or edema. Distal pulses are strong and equal bilaterally.

Neurological examination shows no focal deficits.

EKG obtained upon arrival showed a normal sinus rhythm with rate of 71. PR interval 154, QRS duration 124, QRS axis 62. He did have some ST segment elevations in 2, 3 and AVF with little bit of reciprocal changes in V4,V5 and V6 with some ST depressions. Nitroglycerin drip was started. He was given 5 milligrams of Lopressor IV times three doses. CBC was normal. Basic metabolic profile showed a creatinine of 1.27, otherwise normal. Cardiac enzymes were ordered, chest x-ray showed no mediastinal widening, no evidence of infiltrate or cardiomegaly and he was started on Heparin drip. His pain improved, his repeat EKG showed sinus rhythm with ST segment elevations in 2,3 and AVF were about the same, but there were reciprocal changes in V4,5 and 6 were actually improved.

I spoke with Dr. Cohen who came in to evaluate the patient. The patient was pain free by the time Dr. Cohen arrived and clinically the patient looked a lot better. He will be admitted.

PROVISIONAL DIAGNOSIS:

1. ACUTE MYOCARDIAL INFARCTION.

He will go to the CCU after going to the Catheterization Lab, was admitted in serious condition.

Critical care time: One-half hour.

Russell L. Johnson, D.O. Date

RJ/ajh D: 09/02/2007 11:25 T: 09/05/2007 J#: 252237

Echocardiogram Report

Date: 09/04/2007 **Clinician:**

Status: Final **Encounter:** #104597463- The Toledo Hospital **POC:**

ECHO_EXAM:
PLEASE NOTE: Above date represents the date this report was posted to the CDR, see report content below for the actual exam/observation date.

Patient Name: HALL, BRYCE M MRN: 85454 Visit Number: 104597463

Interpretation Summary
Left ventricular systolic function is moderate to severely reduced. The left ventricle is moderately dilated. The left atrium is mildly dilated. There is moderate mitral regurgitation. There is trace tricuspid regurgitation. Trace pulmonic valvular regurgitation. There is no pericardial effusion.
PatientHeight: 71 in
PatientWeight: 200 lbs
BSA 2.1 m

Study
2D M-Mode and Doppler with Color Flow.

The left ventricle is moderately dilated.
There is normal left ventricular wall thickness.
Left ventricular systolic function is moderate to severely reduced.

The transmitral spectral Doppler flow pattern is normal for age.

The right ventricle is normal size.

The left atrium is mildly dilated.
Right atrial size is normal.

The mitral valve is grossly normal.
There is no mitral valve stenosis.
There is moderate mitral regurgitation.
The effective regurgitant oriface (ERO) of the mitral valve is 9mm2.
The regurgitant volume of the mitral valve is 12cc.

The tricuspid valve is not well visualized, but is grossly normal.
There is trace tricuspid regurgitation.

The aortic valve opens well.
The aortic valve is trileaflet.
No Aortic Stenosis.
No aortic regurgitation is present.

The pulmonic valve is not well seen, but is grossly normal.
There is no pulmonic valvular stenosis.
Trace pulmonic valvular regurgitation.

The aortic root is normal size.

There is no pericardial effusion.

MMode 2D Measurements
IVSd: 0.70 cm
LVIDd: 6.2 cm
LVIDs: 6.1 cm
LVPWd: 0.80 cm
FS: 1.6 %
Ao root diam: 3.3 cm
Ao root area: 8.6 cm
LA dimension: 4.3 cm

Doppler Measurements
MV E point: 84 cm/sec
MV A point: 51 cm/sec
MV E/A: 1.6
MV dec time: 0.14 sec
Ao V2 max: 98 cm/sec
Ao max PG: 4.0 mmHg
LV max PG: 2.0 mmHg
LV V1 max: 68 cm/sec
MR max vel: 409 cm/sec
MR max PG: 67 mmHg

Interpreting Physician: Joel Cohen, D.O. electronically signed on 09-04-2007 17:25:09

History/Physical Report

Date: 09/04/2007 **Clinician:**

Status: Preliminary **Encounter:** #104597463- The Toledo Hospital **POC:**

PLEASE NOTE: Above date represents the date this report was posted to the CDR, see report content below for the actual exam/observation date.

The Toledo Hospital
History

Patient Name	Dictated By	Admission Date	Unit	Room History #
HALL, Bryce M	Joel L Cohen, D.O.	09/02/2007	85454	0750-04

ACCOUNT #: 104597463

HISTORY

The patient is a 57-year-old white male with past medical history of CAD status post CABG who presents with chest pain starting about 4:30 this morning, approximately 2 hours prior to admission. Chest pain was 3/10. No real radiation but he did complain of some funny feelings and pain in his left wrist. Denied shortness of breath. He did admit to nausea but no vomiting. He went to the ER. EKG showed minimal ST elevations in II, III, and aVF with reciprocal changes in the anterior leads. He was given heparin, nitroglycerin, and Lopressor. He had taken an aspirin at home.

PAST MEDICAL HISTORY:

1. Coronary artery disease status post coronary artery bypass graft in 1992 with a LIMA to the LAD and SVG to RCA.
2. Gunshot wound to his back during the Vietnam war.

MEDICATIONS: None.

SOCIAL HISTORY: One pack-per-day of cigarettes, alcohol occasionally.

FAMILY HISTORY: Noncontributory.

PHYSICAL EXAMINATION

He is a pleasant male with some very mild chest pain.
Blood pressure 95/63. Heart rate 63. No JVD.
Heart: Regular rate and rhythm. S1 and S2. No murmurs, rubs, or gallops.
Lungs: Clear to auscultation bilaterally.
Abdomen: Bowel sounds present, soft.
Extremities: No edema.
EKG shows normal sinus rhythm, ST elevation is of approximately 0.5 to 1 mm in II, III and aVF with reciprocal changes in V2-V4.
Hemoglobin 17.7, hematocrit 52.5. Platelets 232,000. Remaining labs are pending.

IMPRESSION: Acute inferior wall myocardial infarction.

PLAN: Emergent cardiac catheterization.

Joel L Cohen, D.O. Date

JLC/bab D: 09/02/2007 07:17 T: 09/04/2007 J#: 252105

TTH Catheterization Report

Date: 09/02/2007 **Clinician:**

Status: Preliminary **Encounter:** #104597463- The Toledo Hospital **POC:**

90000:
PLEASE NOTE: Above date represents the date this report was posted to the CDR, see report content below for the actual exam/observation date.

CATHETERIZATION PROCEDURE REPORT:

Patient Name: HALL, BRYCE M MRN# 85454
Date of Birth: 11-20-1949Age: 57 ACCT # 104597463
Gender: Male Procedure Date: 09-02-2007
Ht: 70.0 inches Wt: 200.0 lbs. Referring Physician: NO PCP, NO PCP
Physician: Cohen, Joel L DO

PROCEDURES PERFORMED:
Left Heart Cath with Selective Coronary Angiography
LV Gram
LIMA Angio selectively cannulated (Graft/Native)
Vein Graft selectively cannulated
INSERT TEMPORARY PACER
PROCEDURE NOT COMPLETED: Unable to advance wire/catheter Circ

INDICATIONS:

Diag Indication: Myocardial Infarction Acute

PROCEDURE SUMMARY:

The patient was brought to cardiac cath lab after acquiring informed consent from patient/family which also includes risks, benefits, and alternatives of the procedure being performed. The patient was prepped and draped in the usual sterile fashion.

Procedural Approach:
Under local anesthesia, the following sheath(s) was/were used:
Cordis 6 Fr Avanti+ Std Sheath (11cm) w/wire
Cordis 6 Fr Avanti+ Std Sheath (11cm) w/wire

Patient transferred to: (verbal report given) CCU
Total Contrast Used: 205.0 ml.
ACCESS: 6 fr standard sheath into Rt femoral artery
6 fr standard sheath into Rt femoral vein
ACT Results during Diagnostic Cath:204 secs, performed in Cath Lab.
08:20:15 , 09-02
ACT Results during Interventional Cath:279 secs, performed in Cath Lab
08:42:22 , 09-02

6 Fr JL 4.0 inserted over the wire.
ACT Drawn performed in Cath Lab.

LCA angiography performed in multiple views.
Catheter removed over the wire.
6 Fr AR Mod inserted over the wire.
RCA angiography performed in multiple views.
SVG Graft to RCA angiography performed in multiple views.
ACT Results: 204 secs, performed in Cath Lab.
Catheter removed over the wire.
6 Fr IM 100cm inserted over the wire.
LIMA Graft to LAD angiography performed in multiple views.
Catheter removed over the wire.
6 Fr Pig 145 110cm inserted over the wire.
LV ventriculography performed in RAO.
Left Vgram - 12 ml/sec - for 36 ml total
Catheter removed over the wire.
Temp Pacer inserted - Rt Fem Vein, 50 ppm, 3 mA, Demand Mode
ACT Drawn performed in Cath Lab.
XB3.5 Guide Catheter introduced:
BMW Guide Wire introduced: Cx
ACT Results: 279 secs, performed in Cath Lab
BMW Guide Wire removed:
Cross-It 100XT Guide Wire introduced:
Cross-It 100XT Guide Wire removed:
Whisper MS Guide Wire introduced:
Physician reviewing films
Physician discussing findings with patient
Whisper MS Guide Wire removed:
MiddleWeight Guide Wire introduced:
MiddleWeight Guide Wire removed:
XB Guide Catheter removed:
Temp Pacer turned off Demand Mode
Temp Pacer removed Demand Mode

The following DIAGNOSTIC SUPPLIES was/were used during this case:
Cordis 6 Fr Avanti+ Std Sheath (11cm) w/wire
Cordis Emerald 0.035" 3mm J Wire 150 cm
Cordis Super Torque 6 Fr JL 4.0
Cordis Super Torque 6 Fr AR Mod
Cordis Super Torque 6 Fr IM 100cm
Cordis High Flow 6 Fr Pig 145 110cm
Cordis 6 Fr Avanti+ Std Sheath (11cm) w/wire
Edwards Lifesciences Bipolar Pacing Catheter 6 Fr

The following INTERVENTIONAL SUPPLIES was/were used during this case:
Cordis Vista Brite Tip 6 Fr XB 3.5
Guidant BMW 0.014" 185cm Wire
Guidant Cross-It 100XT 0.014" 190cm Wire
Guidant Whisper MS 0.014" 190cm Wire
Cordis MiddleWeight J 0.014" 190cm Wire

HEMOSTASIS:
Upon completion of the study, RFA Sutured in
RFV Sutured in

MEDICATIONS GIVEN DURING PROCEDURE:
Heparin 25,000u/500ml D5W @ 1000 units/hr turned off
08:03:55 , 09-02
Nitroglycerin 50mg/250ml D5W @ 5 mcg/min turned off
08:04:03 09-02
IV Bolus: 0.9NaCl 250 ml total bolus
08:04:22 09-02

Dopamine 400mg/250ml D5W @ 5 mcg/kg/min IVPB started
08:12:51 09-02
Heparin 2500 units IV
08:28:09 09-02
IV Fluids: 0.9NaCl decreased to 100 ml/hr
08:36:03 09-02
Dopamine 400mg/250ml D5W @ 2.5 mcg/kg/min decreased rate
09:07:35 09-02
Integrilin Bolus: 8.5 ml IV Push
09:11:12 09-02
Integrilin 75mg/100ml D5W: 15 ml/hr IVPB started
09:14:47 09-02
Integrilin Bolus: 8.5 ml IV Push
09:22:00 09-02

COMPLICATIONS:
No complications

DIAGNOSTIC CARDIAC FINDINGS:
Dominance:
Right Dominant
Left Main Coronary Artery:
LMCA:Normal
Left Anterior Descending:
LAD:Proximal-99% occluded
Circumflex:
CIRC:Proximal-Totally occluded.
Right Coronary Artery:
RCA:Proximal
Graft Vessels:
SVG to RCA: Patent w/ Irregularities Proximal, 40%Lesion
LIMA to LAD: Patent
LV Findings:
Estimated LVEF: 35-40%
LV Wall Motion:
Inferior Apical - Akinesis - Moderate

HEMODYNAMICS:
BSA (m2): 2.09
Hemoglobin (gm/dl): 17.7
REST
HR (bpm): 55
Pressure (mmHg)
Left Ventricle: 72/15, 29
Aorta: 61/44 (52)
Estimated O2 Consumption (ml/min): 277.97

CONCLUSIONS/RECOMMENDATIONS:
Cardiac Diagnostic Recommendations:
Schedule Intervention.
CardiacInterventional Conclusions:
Unsuccessful PTCA - Proximal CIRC.
Cardiac Interventional Recommendations:
Medical Therapy as needed.

Cohen, Joel L DO

The Toledo Hospital
Catheterization Procedure Report
MRN: 85454
NAME: HALL, BRYCE M
DOB: 11-20-1949 GENDER: Male
Procedure Date: 09-02-2007

Signed By: Cohen, Joel L DO - 09-02-2007 09:20:36

Pt. Name: HALL, BRYCE M **Gender:** M **DOB:** 11/20/1949 **Unit#:** 999435240 **MR#:** 85454

Radiology - Chest Report

Date: 09/02/2007 **Clinician:**

Status: Final **Encounter:** #104597463- The Toledo Hospital **POC:**

PATIENT NAME: HALL ,BRYCE

Verified

ADM PHY COHEN, JOEL L
REQ. PHYS.: NON-STAFF,PHYSIC
REQ. SER EC EAST ORDER ID: 6330592
ACC TYP I ADMIT DAT 9/2/2007

Reason: chest pain left arm numbness
Exams: CHEST 1 VIEW PA/AP 71010 2007/09/02 06:25:16
CHEST, ONE VIEW, 09/02/07.
CLINICAL INDICATIONS: Left sided chest pain. Arm numbness.
FINDINGS:
Portable upright frontal view of the chest was performed. There are no previous studies for comparison.
Heart and pulmonary vessels are within normal limits. Lungs and pleural spaces are clear. Sternotomy wires and vascular clips are compatible with previous CABG.
IMPRESSION:
1. THERE IS NO RADIOGRAPHIC EVIDENCE OF ACUTE CARDIOPULMONARY DISEASE.
DICTATED BY: Tamara S. Martin, M.D./rjb
RESULT ID/ADDENDUM:5466221/0

TRAN DATE

DICTATED BY: TAMARA MARTIN, MD RB8824 09/02/2007 13:05
Verified by: TAMARA MARTIN
Page 1 of 1
Verified on: 2007/09/02 16:03:35.00
**** end of result ****

The Toledo Hospital

HALL, BRYCE M
M 57Y 11/20/1949
VS 104659171 MR 85454
KESARI SARIKONDA, MD
ADMIT DATE - 9/27/2007

064

Nursing

Discharge Instructions – How to Care for Your Implanted Device

Discussed below are a few things you should know in caring for your implanted device and implant incision:

1. **KEEP THE INCISION CLEAN AND DRY FOR 7 DAYS.**
The narrow pieces of tape across the incision are called steri-strips. They help support the incision while it is healing. Keep these dry or they will peel off too soon. In 7 days the steri-strips may be removed. You may shower or bathe as you normally do if site is covered with saran wrap and remains dry.

2. **AVOID LIFTING OBJECTS HEAVIER THAN 10 POUNDS OR RAISING ARM ON THE IMPLANTED DEVICE SIDE OVER YOUR HEAD FOR 3 WEEKS FOLLOWING THE SURGERY.**
This will assist in the healing process.

3. **Contact your physician,** Dr. Sarikonda **, AT** 419 865 3939
Normally the implanted device may seem to bulge slightly under your skin. The bulge may be more prominent right after surgery but will become less noticeable over the next two weeks. Changes to notify your physician's office about include:
   - increased swelling and/or tenderness
   - drainage from the incisions
   - a dark or light colored thread (suture) works its way through the incisions
   - you develop a fever and do not have a cold or the flu
   - increased redness of the incisions or if a pimple develops along the incisions

4. **NO DRIVING UNTIL CLEARED BY CARDIOLOGIST.**

5. **NOTIFY YOUR PHYSICIAN OFFICE IF DEVICE DISCHARGES OR IF YOU HEAR BEEPING TONES FROM YOUR PULSE GENERATOR.**

6. **ADVISE DENTIST OR MEDICAL PERSONNEL THAT YOU HAVE AN IMPLANTED DEVICE.**

7. **AVOID CONTACT WITH MAGNETS ON OR NEAR YOUR PULSE GENERATOR.**

8. **CARRY INDENTIFICATION CARD WITH YOU AT ALL TIMES.**

9. **AVOID ASPRIN AND ASPRIN PRODUCTS FOR THE FIRST WEEK FOLLOWING IMPLANT.**
Tylenol may be used for relief of tenderness around the implant site. Also avoid anything that will rub against the incision site.

10. **CONTACT DR.** Sarikonda **SHOULD YOU HAVE A REOCCURRENCE OF THE SYMPTOMS YOU HAD PRIOR TO IMPLANTED DEVICE PLACEMENT.** Resume all home Medications
These symptoms include:
   - dizziness, lightheadedness, passing out
   - very slow heart rate or very fast heart rate
   - unusual shortness of breath or chest pain

11. **FOLLOW-UP VISIT WITH DR.** Sarikonda ~~**IN 6 WEEKS**~~. **CALL FOR YOUR APPOINTMENT** 4 hours 10/04/07

SIGNATURE X _____ **Date** 09/28/07

WITNESS _____

The aortic root is normal size.

There is no pericardial effusion.

Mode 2D Measurements
Sd: 0.70 cm
LVIDd: 6.2 cm
LVIDs: 6.1 cm
LVPWd: 0.80 cm
FS: 1.6 %
Ao root diam: 3.3 cm
Ao root area: 8.6 cm
LA dimension: 4.3 cm

Doppler Measurements
MV E point: 84 cm/sec
MV A point: 51 cm/sec
MV E/A: 1.6
MV dec time: 0.14 sec
Ao V2 max: 98 cm/sec
Ao max PG: 4.0 mmHg
LV max PG: 2.0 mmHg
LV V1 max: 68 cm/sec
MR max vel: 409 cm/sec
MR max PG: 67 mmHg

Interpreting Physician: Joel Cohen, D.O. electronically signed on 09-04-2007 17:25:09

The Toledo Hospital/
Toledo Children's Hospital

HALL, BRYCE M	
0711-01	COHEN, JOEL
M 57Y	COHEN, JOEL
11/20/1949	9/2/2007
MR 85454	VS 104597463

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Discharge Medication Sheet

Date of Discharge 9, 5, 07

MEDICATIONS TO BE TAKEN AFTER YOUR DISCHARGE
CONTACT YOUR DOCTOR BEFORE TAKING ANY MEDICATIONS NOT LISTED BELOW

Medication – (Name, Dose, How to take, When to take)	Reason	Next Time to Take	Prescription Given	Education Given
1) Aspirin 325 mg. 1 tab Daily	mild Blood Thinner			9A
2) Lopressor, 25 mg 1 tab, twice a day	Regulates Heart Rhythm			9A, 6pm
3) Lisinopril (Prinivil) 2.5 mg, 1 tab Daily	Regulates Heart Rhythm			12N
4) Crestor 5mg 1 tab Daily	Lowers Cholesterol			9A

DO NOT TAKE THE FOLLOWING MEDICATIONS

Please bring this list with you whenever you visit your doctor, have testing done or are admitted to the hospital.

Original – Medical Record Copy – Patient

OVER

The Toledo Hospital

HALL, BRYCE M
0711-01
M 57Y
11/20/1949
MR 85454

COHEN, JOEL
COHEN, JOEL
9/2/2007
VS 104597463

100

Discharge Instructions

Date: 9-5-07	Time: 1130	Accompanied by: Daughter
Discharged by: ☐ Ambulatory ☒ Wheelchair ☐ Stretcher ☐ Ambulance / Ambulette		
Discharged to: ☒ Home ☐ Home Care Agency _____ (phone)_____ ☐ Other _____		

Appointments (doctors, clinics, support group)	When	Phone Number
1. Dr. Cohen	call office for appt	419-843-3781
2. Dr.		
3. Dr.		
Lab work and other tests to be done	When	Where
NONE		

Notify your physician, Dr. Cohen **at** office **if the following occurs**

☐ See printed discharge information *Specify:* _____
☐ Wt gain ☐ lightheadedness
☐ Chest pain ☐ _____

Activity ☒ No Restrictions ☐ Shower ☐ Tub ☐ No lifting over _____ lbs.
☐ See printed discharge information *Specify:* _____
☐ _____

Diet ☐ As tolerated
☐ See printed discharge information *Specify:* Low Salt diet
☐ _____

Medications (Provide a copy of discharge medications sheet to patient.)
☒ Discharge Medication Sheet provided and education given.

Original – Medical Record Copy – Patient

年 月 日 时 分 秒
安静时

姓名 男 32 HALL BRY 21208060007
身高
体重
血压
用药
症状
病房
科室

分析心拍:

** 临界（正常）的心电图 **

负荷判断: 可以

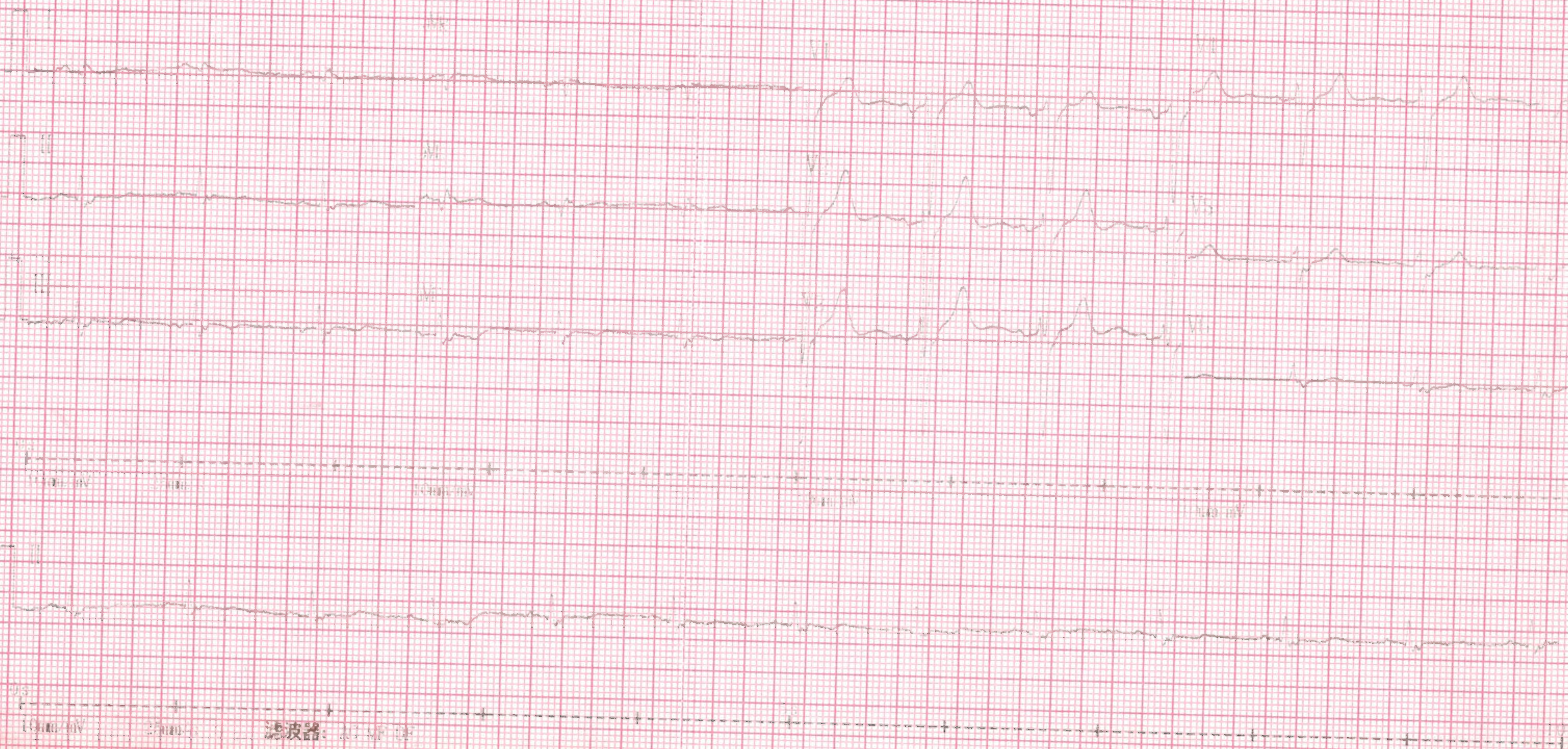
顺时针旋转

注释:

需要医生的确认 : 医生姓名:

轴

明尼苏达码



滤波器:

海口市人民医院

出 院 记 录

姓名：布莱斯.麦克尔　年龄：64岁　性别：男　科室：心血管内科　住院号：0379112

入院日期：2014-10-30　出院日期：2014-11-04　住院天数：05天

入院情况：患者因反复胸闷痛22年，再发伴头晕、黑矇2天。既往1992年因心肌梗塞行冠脉搭桥术，2007年因再次急性心肌梗塞行ICD植入术，否认高血压病、糖尿病等病史，否认肝炎、结核等病史。有鱿鱼过敏史，无药物过敏史。有嗜烟史20余年，平均5支/日，无嗜酒史。无输血史。预防接种史不详。查体：BP118/77mmHg，发育正常，神志清楚，自动体位。双肺呼吸音清晰，双肺均未闻及啰音。无胸膜摩擦音。心前区无隆起，心尖搏动位于左第五肋间左锁骨中线内约0.5cm处，心尖搏动无弥散。心界无扩大，心率76次/分，心律齐，各心脏瓣膜听诊区未闻及心脏杂音，无心包摩擦音。腹部平坦，全腹无压痛及反跳痛。双下肢轻度凹陷性水肿，生理反射存在，病理反射未引出。

入院诊断：冠状动脉粥样硬化性心脏病，劳累型心绞痛，陈旧性前壁心肌梗塞，冠脉搭桥术后，ICD植入术后，心功能Ⅱ-Ⅲ级

主要治疗经过：入院后完善相关检查，心电图：窦性心律，陈旧性前壁心肌梗塞，偶发室性早搏。急查电解质、肾功能及心肌标志物：胱氨酸蛋白酶抑制蛋白C：1.12(mg/L)，肌酸激酶：213.0(U/L)，乳酸脱氢酶：249(u/l)，余均正常。血常规及出凝血五项均正常。生化：总蛋白：60.50(g/L)，同型半胱氨酸：17.33(umol/L)，余均正常；乙肝二对半均正常；传染病三项均阴性；心脏彩超：心脏起搏器置入术后，左心增大，左室壁异常改变考虑：冠心病，主动脉硬化斑块形成，二尖瓣、三尖瓣少量返流，左室舒张功能减退，左室射血、收缩功能轻度受损（EF：44%）。胸片：心脏起搏器安置术后改变。两肺及膈肌未见异常。动态心电图：1.窦性心律；2.偶发性房性早搏 部分成对；3.短阵性房性心动过速；4.频发性室性早搏 部分成对；5.阵发性室性心动过速；6.室内阻滞；7.T波改变。患者于2014-10-31日行ICD装置更换及植入术，术后伤口无渗血。现患者ICD参数如下：心房感知电压：2.1MV，导线阻抗：430Ω；心室感知电压：9.0MV，导线阻抗：380Ω；起搏器模式：DDD，基本频率：60次/分；心房心室起搏电压：2.5V，脉宽：0.5ms；AP 25%,VP 10%;各项参数良好，给予室速治疗模式开始治疗心理次数：196次/分，室颤放电频率：240次/分。现患者一般情况好，无胸闷痛，无头晕、黑矇，无头晕、头痛，要求出院，请示上级医师后同意办理出院手续。

出院诊断：冠状动脉粥样硬化性心脏病，劳累型心绞痛，陈旧性前壁心肌梗塞，冠脉搭桥术后，ICD植入术后，心功能Ⅱ-Ⅲ级

出院医嘱：1.低盐低脂饮食，适当运动；

2.出院带药：胺碘酮片,0.2g,口服；螺内酯片,20mg,口服,qd；福辛普利钠片,10mg,口服,qd；酒石酸美托洛尔片,25mg,口服,bid；阿司匹林肠溶片,100mg,口服,qd；参松养心胶囊,1.2g,口服,tid。（qd：每日1次；bid：每日2次；tid：每日三次）

特别说明：1.胺碘酮片,0.2g,3次/日口服1周后--改为2次/日服用1周--再改为1次/日长期服用。

2.手术1月后继续口服阿司匹林肠溶片。

3.手术1月后周二来我科门诊就诊。

4.不适随诊。

健康教育：心脏起搏器是由微电脑芯片和高能锂-碘电池组成，外壳用钛合金密封，以大约3伏特的直流电脉冲带动心脏规律性收缩。心脏起搏器体积小，重量约25克。通常埋藏在右上胸部的深层皮肤下，故手术创伤很小。它们和人体有良好的相容性，对人体无不良反应。因此，您无须对起搏器埋入体内有不必要的顾虑和担心。然而，起搏器病人应注意什么事情呢？

1．术后（尤其2周内）要避免起搏器侧胳膊高举过头顶，避免较剧烈地咳嗽、打喷嚏、深呼吸和呕吐，这些动作可造成急性或慢性电极脱位。如不得已时，记住必须用力加压按住腹部或加压用腹带并服药，也可以含润喉药，多饮水和食用水果，以减少症状。术后3天以后可下地活动，7天拆线。起搏器病人必须严格预防埋藏起搏器部位皮肤出现任何破损和感染。

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2．约手术后2~3个月以后电极牢固，经起搏器医师检查同意就可以完全恢复日常生活、睡眠姿势、工作、娱乐和体育（非剧烈）活动，例如慢跑、游泳、登山和旅游等，但应避免起搏器侧胳膊单独做高举重物或剧烈地用力挥动动作和运动。

3．现代起搏器对各种外界环境通常具有良好的抗干扰性能，包括生活中所能接触到的家用电器和环境等，例如微波炉、电视机、收录机、电磁炉、电视台、变电站、普通和无绳电话、电脑、飞机和火车、电车、汽车等，因此，病人可安全地使用它们。目前已证实能干扰起搏器工作的有极近距离或极强电磁波/场的情形，例如核磁共振检查；能损坏起搏器的有肿瘤放射治疗仪的辐射。

4．起搏器病人出院后应定期接受医师程控检查和调整起搏器的工作状况，一般为术后第一、三、六个月、一年和每年一次。出现下列情况必须看医生：晕倒、头晕，浮肿（右心衰），脉搏慢而不规则，起搏器部位局部红肿和疼痛，以便医生采取相应措施。

5．起搏器为一次性医疗设备，使用期限主要取决于起搏器内锂-碘电池的寿命，其长短依起搏器类型或起搏器实际工作状态等而定，一般在6~8年。

2/2009